STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLET			ETED	
		155095	B. WIN			10/21/2	011
			В. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				OBSON RD		
HERITAGE PARK					VAYNE, IN46805		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000							
	This visit was for	r the Investigation of	F0	000	The creation and submission		
	Complaint #IN00	0098450.			this Plan of Correction does		
	•				constitute an admission by the		
	Complaint #IN00	0098450-Substantiated.			provider of any conclusion see forth in the statement of	ŧl	
		iciencies related to the			deficiencies, or of any violation	on of	
					regulation.This provider		
	anegation are cit	ed at F325 and F464.			respectfully requests that the	!	
					2567L Plan of Correction be considered the Letter of Credible		
	Survey dates: Oc	etober 20, 21, 2011					
				Allegation.Based on past sur			
	Facility number: 000038				history and no harm identified	d to	
	Provider number	T. 155095			any resident; this facility respectfully requests a desk		
	AIM number: 10	0274830			review in lieu of a		
					post-survey revisit on or after	r	
	Curvey teem:				November 7, 2011.	'	
	Survey team:	TO			·		
	Ann Armey, RN						
	Diane Nilson, Ri	N					
	Census bed type:						
	SNF: 18	•					
	SNF/NF: 145						
	Total: 163						
	Census payor typ	pe:					
	Medicare: 14						
	Medicaid: 108						
	Other: 41						
	Total: 163						
	10001. 103						
	Sample: 5						
	_						
	This deficiency r	eflects state findings					
	1	ace with 410 IAC 16.2.					
	citcu iii accordan	100 WIIII 410 IAC 10.2.					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4L5C11

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155095		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 10/21/2011			
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  2001 HOBSON RD  FORT WAYNE, IN46805				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	2011 by Bev Fau						
F0325 SS=D	assessment, the faresident - (1) Maintains accernutritional status, sprotein levels, unle condition demonst possible; and (2) Receives a the a nutritional proble Based on observate record review, the resident's nutrition new intervention weight loss. This 3 residents whose reviewed in a sare Findings include  On 10/20/11 at 1 entrance tour, acc (Assistant Direct #B was observed blanket.  On 10/20/11, bet	ation, interview, and e facility failed assess the onal status and implement s to address a significant deficiency affected 1 of e weight loss was imple of 5. (Resident #B)	F0325	F325-MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLEIt is the pract of this provider to ensure that resident (1) Maintains accept parameters of nutritional stat such as body weight and profevels, unless the resident's clinical condition demonstrate that this is not possible; and Receives a therapeutic diet withere is a nutritional problem However, based on the alleg deficient practice the following has been implemented: What corrective action will be accomplished for those reside found to have been affected the deficient practice: Reside B: Resident continues to be weighed and reviewed at the Nutrition At Risk Interdiscipling Team Meeting	tice t the table us, tein es (2) when ed eg tents by nt		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 4L5C11

Facility ID:

000038

If continuation sheet

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	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155005			MULTIPLE CONSTRUCTION  UILDING  VING		(X3) DATE SURVEY  COMPLETED  10/21/2011		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN46805					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
	a low wheelchain Her chin was at a drinking coffee a retrieve the coffe finished the coffe propelled herself to her room. She restorative table resident's chin we table top and she retrieve the drink. There was a staff provided verbal at the resident at the her ice cream frow hand and drank to the food on the properties of the clinical reconstruction of the provided but were dementia, weaken the food on the resident at the food on the provided but were dementia, weaken the quarterly assimilated the resimpairment and assistance with example of the weight reconstruction.	one hundred percent of om a bowl she held in her he fluids, but did not eat plate.  In of Resident #B was 20/11 at 1:30 p.m., and ident was admitted to the plate, with diagnoses which we not limited to, less, and hypothyroidism.  Sessment, dated 9/6/11, ident had severe cognitive required limited			weekly.Supervision is providensure resident is encourage consume meal. The Dietary Manager has reviewed food preferences with the resident resident was assessed by an Occupational Therapist and is seated at a table appropriate to meet her needs. Resident receives an supplement BID. Resident is provided snacks between meals. How will you identify or residents having the potentia be affected by the same defi practice and what corrective action will be taken: No other residents were found to have been affected by the alleged deficient practice. Residents presenting with a significant weight loss have the potentiable affected by the alleged deficient practice. Residents weight or nutritional concernative weekly by the Interdisciplinary Team at the Nutrition At Risk Meeting. Team members attending the Nutriat At Risk Meeting have been re-educated. Education including the nutring services. The Director of Nursing Services. The Director of Nursing Services. The Director of Nursing Services of Nursing Services of Certified Dietary Manager is responsited for oversight to ensure compliance. What measures be put into place or what systems.	ed to  t.The  oral  other al to cient  e  al to with s are  am tion udes to g vided rector ector ole will		
FORM CMS-2	2567(02-99) Previous Version	ons Obsolete Event ID: 2	L5C11	Facility I	D: 000038 If continuation s	heet Pac	ge 3 of 11	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	A. BUILDING 00		COMPL	COMPLETED	
		155095	B. WIN			10/21/2011		
		1	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIEF	3			OBSON RD			
HERITA	GE PARK				VAYNE, IN46805			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PROFILE PROPERS PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE		
	follows:				changes you will make to er			
	On 4/1/11, 99 pc	ounds:			that the deficient practice do			
	On 5/1/11, 100 p				not recur:The Dietary Manag			
	On 6/1/11, 96 pc				reviews weekly and monthly			
					weights.Based on the Dietai Managers recommendation-			
	On 7/1/11, 96 pc				residents with weight or nutr			
	On 8/1/11, 95 pc	· · · · · · · · · · · · · · · · · · ·			concerns are reviewed weel			
	On 9/1/11, 89 pc				the Interdisciplinary Team a			
	On 9/6/11, 88 pc	ounds; and			Nutrition At Risk Meeting.A			
	On 10/18/11 (the	e most current weight),			Room Manager observes di			
	was 84 pounds.				service to ensure preferences,			
	was or pounds.				appropriate positioning and			
	The weight reco	rd indicated Resident #B			assistance is provided. Tear			
					members attending the Nutr At Risk Meeting have been	ition		
	_	r 15 percent of total body			re-educated. Education incl			
	1 -	onths (between 4/1/11 and			but is not limited to residents			
	10/18/11) and lo	est 6 pounds or 6.3 per		be reviewed, intervention				
	cent of total bod	y weight in one month			expectations and determining	ng		
	(between 8/1/11	and 9/1/11).			effectiveness.Education pro	vided		
	,				November 4, 2011 by the Di			
	The care plan to	prevent further			of Nursing Services.The Dire			
	_	ht loss, dated 1/25/11,			of Nursing Services/Certified			
	1 -				Dietary Manager is responsi	ibie		
		owing interventions:			for oversight to ensure compliance. How the correct	ive		
	Honor known fo	-			action(s) will be monitored to			
		d fluid intake at meals			ensure the deficient practice			
	Monitor weight,				not recur: A CQI monitoring			
	Notify MD/fami	ly of significant weight			titled "Weight Loss" will be u			
	loss,				every week x 4, monthly x 3			
	1	if less than 75% of any			quarterly thereafter by the D	ining		
	meal is consume	·			Room Monitor.Data will be	#**		
		*			submitted to the CQI commi If the threshold of 90% is no			
	Provide diet as ordered, and				an action plan will be	t illet,		
	Review labs if a				developed.Non-compliance	with		
	All of the above interventions were dated				facility procedure may result			
	1/25/11.				disciplinary action up to and			
					including termination.			
	On 4/18/11, the resident's regular diet was							

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		X1) PROVIDER/SUPPLIER/CLIA	()	(X2) MULTIPLE CONSTRUCTION				(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CURRECTION	IDENTIFICATION NUMBER:	A	A. BUILDING 00 COMPLETED 10/21/2011						
		155095	В	. WING				10/21/2	011	
NAME OF I	PROVIDER OR SUPPLIER	<b>\</b>				RESS, CITY, STA	TE, ZIP CODE			
LIEDITA					2001 HOBSON RD					
HERITAG	GE PARK			FOR	I WA	YNE, IN46805	)			
(X4) ID		TATEMENT OF DEFICIENCIES		ID			AN OF CORRECTION		(X5)	
PREFIX	, i	ICY MUST BE PERCEDED BY FU		PREFIX		CROSS-REFERENCE	E ACTION SHOULD BE D TO THE APPROPRIAT	E	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION	ON)	TAG	_	DEFIC	CIENCY)		DATE	
		l a regular diet with								
	fortified foods w	as ordered.								
	There was no do	cumentation new								
	interventions we	re implemented, to								
	address the resid	ent's weight loss between	n							
	5/1/11 through 9	/1/11 and no								
	documentation th	he effectiveness of the								
	fortified foods w	as assessed.								
	On 1/25/11, diet	tary notes indicated the								
	resident was assessed by the Registered									
	Dietician but there were no further notes									
		ions, from the Registered								
		ling the resident's								
	_	nt loss, until 10/20/11								
	-									
	(nine months late	er).								
	On 0/6/11 dieter	ry notes, written by the								
		r, indicated "Resident								
		ular diet with fortified								
	` `	nt) 61 inches Wt (weight)	'							
		(Body Mass Index)18								
	which is below the									
	_	sumptionsoverall 35%								
	of meals offered.	~								
	· · ·	lems on current diet. Wi	Ш							
	continue to follo									
	_	pounds in the dietary								
	note, did not com	respond to the 88 pound								
	weight recorded	on Resident #B's weight	t							
	record for 9/6/11									
	Interdisciplinary	notes were reviewed.								
FORM CMS-2	.567(02-99) Previous Version	ons Obsolete Event	ID: 4L50	C11 Facil	ity ID:	000038	If continuation sh	eet Pa	ge 5 of 11	

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155095		A. BUII	(X2) MULTIPLE CONSTRUCTION			ETED			
NAME OF I	PROVIDER OR SUPPLIEF	<u> </u>			DDRESS, CITY, STATE, ZIP CODE				
				2001 HOBSON RD FORT WAYNE, IN46805					
	RITAGE PARK			<u> </u>	VATNE, IN40805				
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PROVIDER'S PLAN OF CORR.  PREFIX (EACH CORRECTIVE ACTION SHO					
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	TE	DATE		
		9/13/11, indicated the							
	-	nificant weight loss, the							
	resident's averag	e consumption was 34%							
	and recommende	ed an Occupational							
	Therapy screening	ng.							
	The Occupations	al Therapy Screening,							
	•	idicated the resident was							
		elf without difficulty and							
	no recommendations were made.  The interdisciplinary note, dated 9/28/11,								
	indicated the resident's average								
	consumption was 24% and indicated the								
	resident was scre	eened by the Speech							
	Therapist.								
	Speech therapy i	notes, dated 9/28/11,							
	indicated the res	ident might benefit from							
	• •	provided by therapy, but							
	the resident's por	wer of attorney declined							
	the therapy servi								
	There were no fu	urther recommendations.							
	Physician progre	ess notes, dated 9/30/11,							
	indicated "no ne	w concerns per staff."							
	· ·	nonth after the significant							
	_	identified) the resident's							
		dated and the resident							
	_	eating/swallowing							
	1	e verbal cues and							
		e bite (sic), and verbal							
		on task." the program was							
	7 days a week, 2	meals a day.							

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155095		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  10/21/2011			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  2001 HOBSON RD  FORT WAYNE, IN46805					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	SHOULD BE COMPLETION		
	Subsequent weig	tht records indicated the dditional four pounds		-				
	Dietician was into she had not done recommendation because she was resident's significated the 10/20/11. She indicated the 9/6/11, was writt and the weight us Manager, for the probably from the a result did not a weight loss. The Dietician into BMI (Body Masshad declined and Registered Dietic BMI range was 10 to 10/21/11 at 1 Director was into the resident enjoy drinks provided mocktail activity	0:30 a.m., the Activity erviewed. She indicated yed the cookies and during the twice weekly						
	concerns, dated Director of Nurs	eight and nutritional 1/10, provided by the ing, was reviewed on 0 a.m. and indicated						

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155095		(X2) MULTIPLE CO A. BUILDING	(X3) DATE SURVEY  COMPLETED				
		155095	B. WING		10/21/2011		
	PROVIDER OR SUPPLIER GE PARK		STREET ADDRESS, CITY, STATE, ZIP CODE  2001 HOBSON RD  FORT WAYNE, IN46805				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
	recommendation *Update to care p This Federal tag IN00098450	Registered Dietician) s and follow up					
F0464 SS=D	designated for res These rooms mus ventilated, with no be adequately furr space to accommod Based on observat record review, the the height of a di appropriate for a wheelchair who be loss. This deficite resident's whose and who were ob room, in a sample Findings include On 10/20/11, bet 12:45 p.m., Residential	ation, interview, and e facility failed to assure ning table was resident sitting in a nad experienced weight ncy affected 1 of 3 weight loss was reviewed served in the dining e of 5. (Resident #B)	F0464	F464: REQUIREMENTS FCDINING & ACTIVITY ROOM the practice of this provider to ensure resident dining and a rooms are well lighted; are we ventilated, with nonsmoking identified; be adequately furnished; and have sufficient space to accommodate all activities. What corrective action(s) will be accomplished those residents found to have been affected by the deficient practice: Resident B: Resident seated at a table of appropriate height for dining. How will you identify other residents having potential to be affected by the same deficient practice and we have the provider that the same deficient practice and we have the provider that the same deficient practice and we have the provider that t	SIt is o ctivity rell areas t  d for e lt is ate u g the e		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4L5C11

Facility ID:

000038

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED			
ANDILAN	OF CORRECTION	155095		UILDING 10/21/2011				
		100000	B. WIN			10/21/2	011	
NAME OF I	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP CODE			
LEDITA/	OE DADK				OBSON RD VAYNE, IN46805			
HERITAGE PARK				l .	VATNE, IN46605			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG	<u> </u>	R LSC IDENTIFYING INFORMATION)		TAG	corrective action will be take	NI	DATE	
		r and sitting at a table.			other residents were found to			
		the table level. She was			have been affected by the al			
	_	and had to reach up to			deficient practiceResidents with			
	retrieve the coffe	ee mug. When she			weight loss requiring a low le			
	finished the coff	ee, she left the table and			table to facilitate dining have			
	propelled hersels	f in the wheelchair back			potential to be affected by th			
	to her room. She	e was returned to the			alleged deficient practice.Sk Occupational Therapists have			
	restorative table	in the dining room. The			screened residents in dining			
	resident's chin was again level with the table top and she had to reach up to retrieve the drinking glasses and food.				areas during meals to ensure			
					table heights were appropra	tie for		
					residents residing in the			
	There was a staff person present, who				facility. The Dining Room Mo ensures residents are seated			
	provided verbal prompts.				the appropriate table based			
	-	one hundred percent of			the Occupational Therapist's			
		om a bowl she held in her			recommendation.The facility			
					ordered additional adjustable			
		the fluids but did not eat			height tables to ensure resid			
	the food on the p	olate.			requiring alternate height tat are accommodated.Skilled	oies		
					Occupational Therapists scre	een		
		ord of Resident #B was			residents upon			
		20/11 at 1:30 p.m., and			admission, monthly x 3, qua			
	indicated the res	ident was admitted to the			thereafter and as needed for	-		
	facility on 3/1/10	0, with diagnoses which			appropriate positioning at			
	included but we	re not limited to,			meals.The facility Rehab Se Manager is responsible for	rvices		
	dementia, weakr	ness, and hypothyroidism.			oversight to ensure			
					compliance.What measures	will		
	The quarterly as	sessment, dated 9/6/11,			be put into place or what sys			
		ident had severe cognitive			changes you will make to en			
	impairment and	•			that the deficient practice do not recur:Skilled Occupation			
	assistance with 6	•			Therapists have screened	ui		
		···· 0·			residents in dining areas dur	ing		
	The weight reco	rd, provided by the			meals to ensure table height			
	_	nt Director of Nursing),			were appropratie for residen			
	`	<b>O</b> //			residing in the facility. The Di			
		ent #B's weights were as			Room Monitor ensures resid are seated at the appropriate			
	follows:				are ocated at the appropriate	-		

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TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155095		A. BUILDING B. WING	B. WING		(X3) DATE SURVEY COMPLETED 10/21/2011	
PROVIDER OR SUPPLIE GE PARK	ER	2001	T ADDRESS, CITY, STATE, ZIP C HOBSON RD F WAYNE, IN46805	CODE		
GE PARK  SUMMARY (EACH DEFICIE REGULATORY OF CONTROL ON A 1/11, 99 property of the property of	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION) Tounds; pounds; pounds or 6.3 per pounds or 6.3 pe			iccupational endation. The dditional les to ensure electronate ele	(X5) COMPLETION DATE	
the therapy serv There were no	•					

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/14/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING (COMPLETED)			
		155095	B. WING		10/21/2011
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE  OBSON RD	
HERITAC	GE PARK			WAYNE, IN46805	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	indicated she had eating a snack in but could not rec positioning at a r On 10/21/11 at 1 (Director of Nurs not find a policy dining room table)	d observed the resident the therapy department call assessing her meal.  0:45 a.m., the DON sing) indicated she could regarding the height of			

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